Patient Information		
Name:	Date of birth:	
Sex: ☐ Male ☐ Female ☐ Other	PHIN:	
Home address:	City & Province:	Postal code:
Phone (cell):	Phone (home):	E-mail:

Primary Care Provider Information		
Name:	Phone:	Fax:

Readiness Assessment	
How important is it for you to quit for good?	
How confident are you that you can quit for good?	
How ready are you to quit within the next 30 days?	
When would you like to stop using tobacco products by? (QUIT date)	

What are your motivations for quitting smoking?

☐ Family/relationships ☐ Improve general health ☐ Other existing illnesses
☐ Financial ☐ Other:

Would you like to enrol in the program?	Date of enrolment:

Enrolment Confirmation	
Patient signature:	Pharmacist signature:
**By signing this enrolment form, I (the patient) agree to work with the pharmacist to stop smoking by the proposed QUIT date and consent to sharing my health information with other healthcare providers as needed.*	**By signing this enrolment form, I (the pharmacist) agree to assist the patient in quitting smoking including conducting mandatory patient follow-up appointments at 6 and 12 months.*
Date of initial assessment appointment:	

Initiative Evaluation Consent	
Patient signature:	Date of Consent:
**I understand that my results will be used for evaluation of this smoking cessation initiative only and not myself in any form, and consent to be being contacted to provide feedback.*	

FOR PHARMACIST USE ONLY (Pharmacist Information)	
Pharmacist:	Pharmacy Provider #:
Pharmacist License #:	
Phone #:	Fax #: